Complete Summary

GUIDELINE TITLE

Specialty referral guidelines for cardiovascular evaluation and management.

BIBLIOGRAPHIC SOURCE(S)

American Healthways, Inc. Specialty referral guidelines for cardiovascular evaluation and management. Nashville (TN): American Healthways, Inc; 2002. 26 p. [13 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Cardiovascular disease

GUIDELINE CATEGORY

Management

CLINICAL SPECIALTY

Family Practice
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Hospitals
Managed Care Organizations

Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide primary care physicians treating patients with cardiovascular disease a set of referral guidelines that are balanced and appropriate from the perspectives of the major members of a patient´s health care team

TARGET POPULATION

Persons 18 years of age or greater with cardiovascular disease

INTERVENTIONS AND PRACTICES CONSIDERED

Clinical thresholds that generally indicate the need for referral to a specialist, such as signs and symptoms, disease progression, laboratory/diagnostic/prognostic studies, and response to therapy.

MAJOR OUTCOMES CONSIDERED

Morbidity and mortality associated with cardiovascular disease

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Consensus Development Conference)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

American Healthways convened a Consensus Conference in which physician representatives from primary care, cardiologists, and a variety of other medical specialties together with representatives from managed care organizations, including input from representatives of the American College of Cardiology, developed the guidelines.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A committee of Johns Hopkins faculty and professional staff reviewed the guidelines and found them appropriate for use by primary care physicians and other health professionals.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Referral in the guideline is defined as "A request by a physician or other provider for an interaction between a patient and a cardiologist or other appropriate specialist for consultation, evaluation and/or management".

Chest Pain And Coronary Artery Disease

(Includes stable angina and acute coronary syndrome [unstable angina and myocardial infarction (MI)])

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Acute coronary syndrome	• Unstable Angina • Acute Myocardial Infarction • Patients with elevated markers of cardiac injury	Refer to cardiologist.
Patients Post Revascularization (PCTA/Stent/Coronary Artery Bypass) < 12 months	• Asymptomatic	Cardiologist evaluation or follow-up as determined jointly by Primary Physician and specialist.
	• Emergence of symptoms similar to pre-operative ischemia equivalents or symptoms suggesting "new" ischemia	Refer to cardiologist for earlier than scheduled evaluation.
	• Failure to readily achieve goals for preventive therapy	Consider referral to appropriate specialist.
Patient with known coronary artery disease including those with revascularization procedures	• Stable • LVEF <45%	Consider referral to cardiologist on annual basis for overview of risk factor management and reassessment of adequacy of preventive therapy.
	• Progression of symptoms • Significant changes in EKG • New congestive heart failure or declining LVEF • Emergence of	Refer to cardiologist.

	significant arrhythmia • Clinical or imaging evidence of significant inducible ischemia	
	• Failure to readily achieve goals for preventive therapy	Consider referral to appropriate specialist.
Chest discomfort of uncertain etiology or other symptoms suggestive of myocardial ischemia	• Multiple emergency room visits for chest discomfort without a definitive diagnosis, but has clinical suspicion of CAD • Chest discomfort, atypical for ischemia, in a patient with two or more major coronary risk factors • Chest discomfort suspicious for angina • Symptoms suggestive of myocardial ischemia	Refer to cardiologist.

Abbreviations: CAD, coronary artery disease; EKG, electrocardiogram; LVEF, left ventricular ejection fraction; PCTA, percutaneous transluminal coronary angioplasty

Abnormal Screening Tests

(This referral guideline should not be construed as supporting the use of routine screening for coronary calcium.)

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Abnormal screening tests for cardiovascular disease	Abnormal stress test	Refer to cardiologist.

	• Presence of multiple risk factors • Change in ECG • Evidence of significant cerebrovascular or peripheral vascular disease • Abnormal result of coronary calcium score in upper quartile of age adjusted results.	Consider referral to cardiologist or other appropriate specialist based on individual patient needs.

Abbreviations: ECG, electrocardiogram

Pre-Operative Evaluation

(For patients whose surgery requires or may require general or spinal anesthesia.)

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Patients at Increased Peri-Operative Risk	• Angina (CCS class 2, 3 or 4) • Recent MI (within 6 months) • Significant AS, valve area <1.5 cm^2 • Uncontrolled arrhythmias • Malignant hypertension • AF with uncontrolled ventricular response • Patients undergoing vascular surgery • Implanted defibrillator • Unexplained syncope • Congestive heart failure (NYHA class 3 or 4) or evidence of severe left ventricular dysfunction • Patients with mechanical valves	• Referral to cardiologist is appropriate for pre-operative evaluation. • Peri-operative follow-up as mutually agreed upon by primary care physician, surgeon, and cardiologist.

	• Hypertrophic obstructive cardiomyopathy (HOC) • Patients with diabetes with poor functional capacity	
High Risk Surgery with greater than 5% cardiovascular mortality (e.g. emergent major operations, aortic and major vascular, peripheral vascular, prolonged surgery with large fluid shifts or blood loss)	• Poor functional capacity (less than 4 METs)	Referral to cardiologist is appropriate for pre-operative evaluation.
Patients at Low Peri-operative Risk	• Past history of AF or well-controlled AF >1 year • NYHA class 1 or 2 CHF • Mild AS, valve area >1.5 cm 2 • Rare ventricular ectopic activity with normal LV function • Patients on anti-coagulation therapy • Stable pacemaker patient Prior history of SVT • Compensated valvular disease, except AS (see above for AS) • Controlled hypertension • Myocardial infarction >6 months	Cardiology referral at physician´s discretion.

Abbreviations: AF, atrial fibrillation; AS, aortic stenosis; CCS, Canadian Classification System; CHF, congestive heart failure; LV, left ventricular; METs, metabolic equivalent tasks; MI, myocardial infarction; NYHA, New York Heart Association; SVT, supraventricular tachycardia

Hypertension

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Hypertensive Emergencies	• Malignant hypertension, as evidenced by: -Papilledema -CHD -Neurologic signs or symptoms -Rapidly deteriorating renal function -Acute cardiac ischemia	Immediate referral to physician with expertise in the management of hypertension.
Refractory or Severe Hypertension	• Failure to reach targets on conventional therapy for six to twelve months (see Pertinent Clinical Targets in original guideline document).	Refer to physician with expertise in the management of hypertension until goals met.
	• Severe hypertension BP >220/120 mm Hg	Consider referral to physician with expertise in the management of hypertension.
Possible Secondary Causes of Hypertension	• Creatinine $\geq$2.0 mg/dL, $\geq$ or 2+ dipstick proteinuria • Unexplained hypokalemia • Hyperadrenergic signs and symptoms (diaphoresis, tremor, palpitations, paroxysms of hypertension) • Signs and symptoms of	Indication for more extensive work-up for secondary causes of hypertension, and/or referral to physician with expertise in the management of hypertension, for evaluating potential secondary causes.

	Cushing´s syndrome (central obesity, easy bruise ability, proximal muscle weakness, striae) • Age <30 years • Sudden elevation of BP in previously stable patient • Abdominal bruit • BP differential in arms or legs	
Evidence of End Organ Damage	• Heart: ECG, CXR, or echocardiogram suggesting ischemic heart disease, or evidence of LV abnormality such as LBBB or LVH, • Kidney: Proteinuria, azotemia • Eye: Retinopathy • Cerebrovascular disease • Peripheral vascular disease	Indication for more intensive therapy or referral to appropriate specialist.

Abbreviations: BP, blood pressure; CHF, congestive heart failure; CXR, chest X-ray; ECG, electrocardiogram; HTN, hypertension; LBBB, left bundle branch block; LV, left ventricular; LVH, left ventricular hypertrophy

Lipids And Metabolic Syndrome

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Refractory Dyslipidemia	• Failure to meet NCEP (ATP III) goals in 12 months (or 6 months in patients with recent CV event) (see Pertinent Clinical Targets in original guideline	Refer to physician with expertise in the treatment of lipid disorders.

	document).	
Metabolic Syndrome (This syndrome has been associated with high risk for future development of coronary artery disease) Patient with at least 3 of the following: • Fasting triglycerides >150 mg/dL • HDL <40 mg/dL in male, <50 mg/dL in female • Increased waist circumference >40 inches in male, >35 inches in female • Hypertension with BP >130/85 • FBS >110 mg/dL	• Failure to meet NCEP (ATP III) goals after 12 months	Consider referral to physician with expertise in the treatment of this disorder.
	• High risk patients using ATP III risk assessment, and/or other risk stratification or screening for the presence of CAD	Consider referral to cardiologist.

Abbreviations: ATP, Adult Treatment Panel; BP, blood pressure; CAD, coronary artery disease; CV, cardiovascular; FBS, fasting blood sugar; HDL, high density lipoprotein; NCEP, National Cholesterol Educational Program

Heart Failure

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Heart Failure (decreased or preserved systolic function)	Decompensated as evidenced by: • Need for parenteral IV asoactive drugs • ≥2 ER visits or hospital admissions for heart failure in 6 months • Current admission to ICU/CCU for heart failure • Systolic blood pressure <90 • Worsening renal	Refer to cardiologist or heart failure specialist/program.

	function • Significant arrhythmias • Manifestations of myocardial ischemia • Syncope or near syncope • Refractory to medical therapy • Worsening LV function	
	• Stable Non-adherent or non-compliant	Consider referral to heart failure specialist/program, health educator, case manager, behavior change specialist, or cardiologist
	• Ejection fraction by imaging <30%	Refer to cardiologist
	• Newly diagnosed heart failure	Consider referral to cardiologist with mutually agreed upon follow-up between specialist and referring physician.

Abbreviations: CCU, critical care unit; ER, emergency room; ICU, intensive care unit; IV, intravenous; LV, left ventricular

Arrhythmias Or Syncope

(Excluding PACs, premature ventricular contractions [PVCs])

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Atrial Fibrillation or Flutter (paroxysmal or persistent)	• Signs and/or symptoms of congestive heart failure • Symptomatic hypotension • Worsening angina	Refer to cardiologist for evaluation with follow-up as determined by cardiologist in concert with Primary Care Physician.

	• Uncontrolled ventricular response rate including with exertion • Embolic phenomena • Symptomatic bradycardia or pauses in excess of three (3) seconds • New onset atrial fibrillation • Consideration of cardioversion or Class I or Class III antiarrhythmic drug therapy* • Intolerance of or unresponsiveness to standard therapy • Worsening left ventricular function • Syncope or other CNS symptoms • Evidence of significant valvular heart disease	
Other Supraventricular Tachycardias	(Signs and symptoms as described above for atrial fibrillation) • Recurrent sustained SVT (>30 seconds duration)	Refer to cardiologist or cardiac electrophysiologist for evaluation with follow-up as determined by cardiac specialist in concert with Primary Care Physician.
	• Wolff-Parkinson-White syndrome or other ventricular pre-excitation on ECG • Recurrent or persistent atrial flutter	Refer to cardiologist for evaluation with follow-up as determined by cardiologist in concert with Primary Care Physician.
Atrioventricular (AV) block	• 3rd degree AV block • 2nd degree AV block Mobitz II • 2nd degree AV	Refer to cardiologist for evaluation with follow-up as determined by cardiologist in concert

	block Mobitz I (Wenckebach) symptomatic	with Primary Care Physician.
	• 2nd degree AV block Mobitz I (Wenckebach) asymptomatic • Marked 1st degree AV block	Consider referral to cardiologist.
Implanted Cardiac Devices		Periodic review by cardiologist or cardiac electrophysiologist.
Abnormality on ECG or ambulatory ECG monitor	• Wolff-Parkinson-White or ventricular pre-excitation syndrome • Prolonged QT syndrome • Tachy-brady syndrome	Refer to cardiologist or cardiac electrophysiologist for evaluation with follow-up as determined by cardiologist in concert with Primary Care Physician.
	• Bifascicular block • New onset LBBB	Consider referral to cardiologist
Syncope or Near-Syncope	• Abnormal ECG or cardiovascular evaluation • Unexplained after initial evaluation	Refer to cardiologist for evaluation with follow-up as determined by cardiologist in concert with Primary Care Physician
Other Bradyarrhythmias	• Symptomatic, or • Heart rate <45	Refer to cardiologist for evaluation with follow-up as determined by cardiologist in concert with Primary Care Physician Consider referral to cardiologist
NonSustained Ventricular Tachycardia (<30 seconds in	• >3 beats with structural heart	Refer to cardiologist for evaluation with follow-

duration)	disease • Symptomatic	up as determined by cardiologist in concert with Primary Care Physician.
	• Asymptomatic with no structural heart disease	Consider referral to cardiologist for evaluation with follow-up as determined by cardiologist in concert with Primary Care Physician.
Sustained Ventricular Tachycardia, Ventricular Fibrillation or Out of Hospital Cardiac Arrest (>30 seconds duration or requiring emergency therapy before 30 seconds duration)		Immediate referral to cardiologist or cardiac electrophysiologist for evaluation with follow-up as determined by cardiac specialist in concert with Primary Care Physician.
Other	• Patients receiving antiarrhythmic drugs (Class I and Class III)* • Frequent or symptomatic PVCs	Consider referral to cardiologist for evaluation with follow-up as determined by cardiologist in concert with Primary Care Physician.

Abbreviations: AV, atrioventricular; CHF, congestive heart failure; CNS, central nervous system; ECG, electrocardiogram; LBBB, left bundle branch block; SVT, supraventricular tachycardia

*Antiarrhythmic Agents by Class

Class I

Quinidine, IA

Procainamide, IA

Disopyramide, IA

Lidocaine, IB

Mexiletine, IB

Tocainide, IB

Phenytoin, IB

Flecainide, IC

Propafenone, IC

Encainide, IC

Moricizine, IC

Class I I I

Amiodarone

Bretylium

Sotalol

Ibutilide

Dofetilide

Azimilide

Valvular Heart Disease

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Known or suspected valvular heart disease or prior valvular surgery.	• New or recurrent arrhythmias • Syncope • Angina • Neurologic presentations • Significant change in murmur • Unexplained fever or suspected endocarditis • Signs or symptoms of heart failure • Signs or symptoms of embolic phenomenon (e.g., Amaurosis Fugax) • Significant change in echocardiogram • Change in baseline ECG	Referral to cardiologist for earlier than scheduled re-evaluation, with follow-up as recommended by cardiologist. For all patients with hemodynamically important VHD, or prior valvular heart surgery, a longitudinal management plan should be developed by the cardiologist.

	• Decreasing cardiovascular functional capacity • Unexplained murmur despite recent echocardiogram	

Abbreviations: ECG, electrocardiogram; VHD, valvular heart disease

Congenital Heart Disease

(In the adult patient >18 years of age)

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Lesions (operated or unoperated) such as: • Tetralogy of Fallot • Transposition of great vessels • Right ventricular dysplasia • Ostium primum ASD (cushion defect) • Eisenmenger syndrome • Secundum ASD • Ventricular septal defect without Eisenmenger physiology • Coarctation, PDA, etc.	Asymptomatic	Initial evaluation by adult or pediatric cardiologist with follow-up as determined by cardiologist. Consider referral to sub-specialist with special training/experience in congenital heart disease.

	Symptomatic • Atrial and/or ventricular arrhythmias • Syncope • Hypertension (status post coarct repair) • Heart failure • Angina • Cyanosis • Respiratory Insufficiency	Refer to cardiologist for earlier than scheduled reevaluation.

Abbreviations: ASD, atrial septal defect; PDA, patent ductus arteriosus

Pregnant Or Contemplating Pregnancy

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Pregnant, Contemplating Pregnancy, or Women of Child Bearing Potential.	• Significant valvular disease • Uncontrolled hypertension • Chronic anticoagulation for cardiovascular indication • Congenital heart disease • Left ventricular dysfunction, or prior history of peripartum cardiomyopathy • Known coronary disease • Pulmonary hypertension • Marfan´s Syndrome • Hypertrophic	Should be referred to cardiologist or other appropriate specialist for evaluation and ongoing care. Patients with a need for chronic cardiovascular pharmacotherapy may need referral to specialist if Primary Physician is unfamiliar with teratogenicity of these drug classes.

	obstructive cardiomyopathy • Significant arrhythmias • Cardiomyopathy	

Other

Groups/Classes/Categories	Triggers: Key Things to Look For	Referral Guideline
Conditions including but not limited to: • Hypertrophic cardiomyopathy • Pericardial diseases • Marfan´s Syndrome • Cardiac tumors • Aortic dissection	• Discovery	Refer to cardiologist.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations offered in the original guideline document are based on peer-reviewed scientific publication and the collective expertise of the physicians participating in the consensus conference.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate referral of patients with cardiovascular disease (CVD) to physician specialist

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- In using these guidelines, primary physicians are urged to take into account such factors as their own interest, time and expertise, regional practice patterns, availability of specialists and insurance considerations. On balance it is suggested that it is better to refer in questionable situations than not to refer when indicated, remembering that the purpose of consultation is to add value to the patient´s management.
- The nature of a referral can only be determined by the referring physician and follow-up should be mutually agreed upon by the specialist and referring physician. Not every referral need be for the purpose of ongoing specialty care. Appropriate referrals, given the history of other pertinent indicators, might be for testing, consultation, short- or long-term follow-up, or co-management. Added value may accrue across the entire spectrum of consultant participation.
- Because of the chronic, complex and inhomogeneous nature of cardiovascular disease, multiple environmental factors may influence the patient´s and physician´s ability to achieve desired goals. These include, but are not limited to, behavioral issues, psychosocial issues and socioeconomic issues. Since it is impossible to generalize as to the impact of these factors in an individual situation, physicians are advised to consider any such modifying factors in their application of these referral guidelines.
- Variation from these guidelines is always acceptable if, in the opinion of the referring physician or provider, individual circumstances require it.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Healthways, Inc. Specialty referral guidelines for cardiovascular evaluation and management. Nashville (TN): American Healthways, Inc; 2002. 26 p. [13 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2002

GUIDELINE DEVELOPER(S)

American Healthways, Inc - Public For Profit Organization

GUIDELINE DEVELOPER COMMENT

American Healthways convened a Consensus Conference in which physician representatives from primary care, cardiologists, and a variety of other medical specialties together with representatives from managed care organizations, including input from representatives of the American College of Cardiology, developed the guidelines.

SOURCE(S) OF FUNDING

American Healthways, Inc.

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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*Representatives of the American College of Cardiology (ACC)

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American Healthways, Inc. Web site.

Print copies: Available from American Healthways, Inc., 3841 Green Hills Village Drive, #300, Nashville, TN 37215.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on September 17, 2002. The information was verified by the guideline developer on October 24, 2002.

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